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Issue Date: 10 April 2003

IN THE MATTER OF:

MARVIN PROFFITT,
Claimant,

v. Case No.: 2001-BLA-170

FALCON COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

DECISION AND ORDER AWARDING LIVING MINER'S BENEFITS ON REMAND

This case arises from a claim for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. § 901 *et seq.* ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718 and 725. By *Decision and Order* dated August 28, 2002, the Benefits Review Board (Board) remanded this case for reconsideration of the evidence under 20 C.F.R. §§ 718.202(a) and 718.204(c). In particular, the Board held the following:

- the undersigned erred in discrediting Dr. Branscomb's statement that his positive chest x-ray reading was due to Claimant's "morbid obesity" and did not reflect the presence of pneumoconiosis;

- it was proper for the undersigned to consider the fact that Dr. Branscomb was not a B-reader at the time he interpreted the x-ray study and that his credentials, along with the credentials of the other readers, must be considered in assessing the credibility of the x-ray readings;

- it was error to credit the most recent positive chest x-ray study on grounds that it post-dated a negative study by four months and the undersigned must provide "more explanation and discussion for why he finds that x-ray more credible, where the x-rays are only separated by a short period of time";

- the undersigned must weigh the chest x-ray and medical opinion evidence together under 20 C.F.R. § 718.202(a) pursuant to the Fourth Circuit's holding in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000) to determine whether coal workers' pneumoconiosis is present;

- the undersigned properly applied the amended regulatory standard at 20 C.F.R. § 718.204(c) for determining the etiology of the miner's total disability;

- it was proper for the undersigned to accord greater weight to the opinion of Dr. Rasmussen regarding etiology over the opinions of Drs. Fino, Castle and Branscomb given Dr. Rasmussen's superior credentials;

- the undersigned must explain why Dr. Forehand's opinion regarding causation was entitled to greater weight given that Drs. Fino, Castle, and Branscomb "provided better explained opinions;"

- the miner's smoking history must be reassessed as the undersigned found an 8 to 10 pack year of smoking cigarettes, which is consistent with Claimant's testimony that he started smoking at the age of 25 years (which is 1972 since Claimant was born in 1948) and he smoked one-half a pack per day until his first heart attack in 1988 at which point Claimant quit and Claimant reported a 10 to 30 year smoking history to physicians where Claimant consistently stated that he smoked one-half a pack of cigarettes per day and, according to the Board, this would "appear to support" the undersigned's finding of an 8 to 10 pack year history;

- the undersigned must reassess the opinions of Drs. Fino and Castle with regard to the cause of Claimant's total disability given that they assumed heavier smoking histories; and

- Dr. Branscomb's opinion regarding etiology under § 718.204(c) must be reassessed given his explanation of the positive x-ray reading.

I
Existence of pneumoconiosis

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a).[1]

The regulation at 20 C.F.R. § 718.202(a)(1) requires that "where two or more X-ray reports

[1] There is no autopsy or biopsy evidence in this record and the presumptions contained at §§ 718.304 - 718.306 are inapplicable such that these methods of demonstrating pneumoconiosis will not be discussed further.

are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[2] In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

Reference is made to page 3 of the undersigned's September 21, 2001 *Decision* wherein the chest x-ray evidence is charted. There are six studies of record. A study dated February 2, 2000 was interpreted as positive by a dually-qualified physician and a B-reader. It was interpreted negatively by three dually-qualified physicians. Based on a preponderance of the interpretations of dually-qualified physicians, the undersigned finds that the study does not support a finding of pneumoconiosis.

A study conducted on June 28, 2000 was interpreted as positive by a B-reader and this reading remains uncontradicted. Therefore, it supports a finding of the disease.

The July 6, 2000 study was interpreted by three dually-qualified physicians as negative for the presence of the disease. As a result, this study does not support a finding of pneumoconiosis.

The December 12, 2000 study was interpreted positively by a dually-qualified physician and by Dr. Rasmussen, who is a B-reader. However, three dually-qualified physicians conclude that the study does not support a finding of the disease. Greater weight is accorded the preponderantly negative interpretations of the dually-qualified physicians.

The January 13, 2001 study was interpreted as positive by a dually-qualified physician, whereas three dually-qualified physicians found that it did not support a finding of the disease. One of these dually-qualified physicians, Dr. Gayler, concluded that the study demonstrated Category 0/1 pneumoconiosis. This is insufficient to support a finding of the disease under the regulations.

Finally, the May 14, 2001 study was interpreted positive by Dr. Castle, who is a B-reader. He found Category 1/1 pneumoconiosis in all six lung zones and there are no contrary readings of this study in the record.

Based on the foregoing, the miner has established that he suffers from pneumoconiosis based

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[2] A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

on the chest x-ray evidence of record. In the undersigned's previous *Decision*, the most recent study was accorded greater weight because "pneumoconiosis is a progressive disease" and the only interpretation of the May 2001 study was by a B-reader and it was positive.

The Board held that, although it is proper to accord greater weight to the more recent chest x-ray evidence of record, the undersigned must provide more of an explanation where only a four to five month span of time separates the most recent study from the two previous (and preponderantly negative) studies of record.

The Fourth Circuit has approved of application of the "later evidence" rule where the evidence tends to demonstrate a worsening condition. *Eastern Assoc. Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000); *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992) (the later evidence rule is properly used where the later x-ray studies were not inconsistent with earlier studies given the progressiveness and irreversibility of pneumoconiosis). Although the undersigned does not have years of positive chest x-ray readings upon which to base a finding of the disease, it is evident that the studies demonstrate the development of regulatory significant pneumoconiosis in its beginning stages. It is noteworthy that Dr. Gayler, who is a dually-qualified physician, consistently found Category 0/0 pneumoconiosis upon review of the February 2000, July 2000, and December 2000 x-ray studies. By the time of the June 2001 study, taken six to 18 months after the prior studies, Dr. Gayler found Category 0/1 pneumoconiosis. Hence, it is logical that opacities were developing at that time, which were sufficient in size and number for him to consider a Category 1 reading. By the time of the May 2001 study, it is reasonable that the opacities had further developed such that Dr. Castle, who is a B-reader, concluded that the study revealed Category 1 pneumoconiosis.

Moreover, as the Board acknowledged, the undersign's *Decision* finds it significant that the six positive readings – all the positive B-readings other than that by Dr. Branscomb – were by different B-readers, three of whom were also Board-certified radiologists, while the twelve negative interpretations represented readings by only three different B-readers.

Therefore, it is determined that the chest x-ray evidence, read in its totality, establishes the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(1).

Claimant can also establish that he suffers from the disease is by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields*, *supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc).

Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). The following medical reports were submitted as evidence in this record:

1. Dr. J. Randolph Forehand examined and tested the miner and issued his report on February 2, 2000. *Dx.* 8. He noted a 23 year history of coal mine employment as well as a 15 year history of smoking one-half a pack of cigarettes per day. On examination, Dr. Forehand reported that the miner's breath sounds were of "normal quality and distribution." A chest x-ray study was interpreted as revealing Category 1 pneumoconiosis. Ventilatory testing produced evidence of an obstructive pattern and blood gas testing established hypoxemia. Dr. Forehand diagnosed coal workers' pneumoconiosis based on the positive chest x-ray reading and blood gas study results. He further found that the miner suffered from chronic bronchitis due to smoking and coal dust exposure. Dr. Forehand concluded that the miner's respiratory impairment was totally disabling.

2. Dr. Gregory Fino examined and tested the miner, reviewed certain medical records, and issued his report on July 13, 2000. *Ex.* 1. He further testified as to the conclusions contained in his report by deposition conducted on September 20, 2000. *Ex.* 2. Although Dr. Fino concluded that the miner suffered from coal workers' pneumoconiosis based on a positive chest x-ray reading and that the miner was totally disabled due to a respiratory impairment, Dr. Fino stated that the cause of the respiratory impairment was Claimant's tobacco abuse. He noted a 23 year coal mine employment history as well as a history of smoking one-half a pack of cigarettes per day for 20 years. Examination of the lungs revealed "decreased breath sounds," which he found were "consistent with a diagnosis of pulmonary emphysema." He interpreted a chest x-ray study as revealing Category 1 pneumoconiosis in the upper zones, which was consistent with coal workers' pneumoconiosis. His interpretation remains uncontradicted on this record. Ventilatory testing revealed the presence of a moderate obstruction and the miner demonstrated moderate hypoxia on blood gas testing. Dr. Fino also noted that the miner's carboxyhemoglobin level was two percent, which indicated that he was "being exposed to products of combustion." Dr. Fino concluded that the miner had "clinical evidence" of coal workers' pneumoconiosis. He also diagnosed emphysema and chronic bronchitis secondary to the miner's smoking history. Dr. Fino found that Claimant had a moderate respiratory impairment and was totally disabled from returning to work. The miner's total disability is due solely to his smoking history. Dr. Fino reasoned that a Category 1 abnormality on a chest x-ray indicates "such a low profusion" that it "would not cause an impairment."

   During his deposition, Dr. Fino stated the following with regard to the cause of the miner's totally disabling respiratory impairment:

   > I don't even believe that chronic bronchitis is the cause of his impairment in ventilatory function. I believe that it's all related to

> emphysema, and I believe that it's due to smoking and that has caused the fixed, irreversible obstruction with elevated lung volumes and a reduction in diffusion.

Ex. 1 at 9. He further stated that coal workers' pneumoconiosis can cause minor obstructions which do not cause impairment but "[t]he impairing or disabling type of obstructive abnormality is associated with restriction due to significant scarring and fibrosis from pneumoconiosis that would be seen in very high categories of pneumoconiosis, such as a three slash two or greater." *Ex.* 1 at 9-10. Dr. Fino noted that there was no restrictive component to the miner's ventilatory study results.

During his deposition, he opined that simple coal workers' pneumoconiosis can be totally disabling if it occurs with a significant drop in the blood oxygen level with exercise or in conjunction with a significant decrease in the breathing tests with a concomitant restrictive defect. *Ex.* 1 at 20. Dr. Fino further noted that "restriction is really unusual unless there's a much higher profusion abnormality." *Ex.* 1 at 20. When asked by Claimant's attorney whether Claimant's blood gas test results during exercise, revealing a PO2 of 61.5, demonstrated that the miner was totally disabled under the regulations, Dr. Fino responded that he did not "go by those regulations" and that he does not determine whether someone is disabled "just because they meet the regulatory standards." *Ex.* 1 at 23-24. Dr. Fino further testified that simple coal workers' pneumoconiosis cannot cause a purely obstructive respiratory impairment; rather, it can "cause a pure obstructive abnormality." *Ex.* 1 at 20-21. Finally, Dr. Fino stated that coal dust exposure cannot aggravate an obstructive respiratory disease. *Ex.* 1 at 22.

3. Dr. D.L. Rasmussen examined and tested the miner and issued his report on December 12, 2000. He noted that the miner complained of shortness of breath and a chronic, productive cough. Dr. Rasmussen reported 23 years of coal mine employment as well as a history of smoking one-half a pack of cigarettes per day for 18 years. On examination, he noted that the miner's breath sounds were minimally reduced and that there were transient bilateral basilar rales, and a prolonged expiratory phase with forced respirations. A dually-qualified physician, Dr. Patel, interpreted the chest x-ray as Category 1 pneumoconiosis in all lung zones. Ventilatory testing revealed a moderate, irreversible obstructive impairment. The miner's maximum breathing capacity and diffusing capacity were minimally reduced and he demonstrated moderate resting hypoxia. Dr. Rasmussen concluded that the miner suffered from a totally disabling respiratory impairment arising from his smoking and coal mine employment histories.

4. Dr. Ben Branscomb reviewed certain medical records and issued his report on January 9, 2001. He found that a chest x-ray study yielded Category 2 pneumoconiosis. However, he reported that the opacities seen on the chest x-ray were not caused by pneumoconiosis; rather, they were caused by the miner's obesity. He concluded that the miner suffered from a totally disabling respiratory impairment due to smoking-induced chronic obstructive

pulmonary disease and obesity. Dr. Branscomb reported a 23 year history of coal mine employment as well as a history of smoking one-half a pack of cigarettes per day for 15 to 20 years. He noted, during his March 6, 2001 deposition, that cigarette smoking is the most common cause of chronic obstructive pulmonary disease. *Ex.* 2 at 29.

5. Dr. James Castle examined and tested the miner, reviewed certain medical records, and issued his report on July 12, 2001. He noted 18 years of coal mine employment and that the miner smoked one-half a pack of cigarettes for 15 years, quitting in 1988 when he had a heart attack. Dr. Castle stated that the miner's wife continues to smoke and she smoked in the car while driving to the examination. On examination, Dr. Castle noted coarse breath sounds and a "few scattered rhonchi which cleared with deep breathing." He diagnosed the presence of coal workers' pneumoconiosis based on a chest x-ray, which he interpreted as revealing Category 1 opacities in all lung zones. His interpretation remains uncontradicted on this record. He further found that the miner suffered from mild to moderate airway obstruction without reversibility. Dr. Castle also noted that there was no evidence of restriction, but there was gas trapping. Blood gas testing revealed mild hypoxemia. He diagnosed simple coal workers' pneumoconiosis based on the chest x-ray study as well as smoking-induced chronic obstructive pulmonary disease. Dr. Castle stated that "[t]he data clearly would substantiate the fact that (Claimant) has a much more excessive smoking history than he had indicated." Dr. Castle reasoned that the miner's chronic obstructive pulmonary disease was caused by smoking because the miner exhibited a pure obstruction, without restriction, as well as gas trapping, and a minimum reduction in diffusing capacity after correction for alveolar volume. He stated that coal workers' pneumoconiosis generally causes a mixed impairment. Dr. Castle noted that the miner's blood gas study values demonstrated hypoxemia, but they improved slightly with exercise, which would not have happened if the hypoxemia was due to coal workers' pneumoconiosis.

Initially, it is noted that the undersigned continues to find that Claimant had an eight to ten pack year history of smoking cigarettes. This is consistent with the miner's credible testimony that he started smoking one-half a pack of cigarettes per day in 1972 and he quit smoking in 1988, after he suffered a heart attack (which constitutes an 8 pack year smoking history). The following smoking histories were reported by the physicians:

- Dr. Forehand — 15 years of smoking one-half a pack of cigarettes per day
- Dr. Rasmussen — 18 years of smoking one-half a pack of cigarettes per day
- Dr. Branscomb — 10 years of smoking one-half a pack of cigarettes per day
- Dr. Fino — 20 years of smoking one-half a pack of cigarettes per day
- Dr. Castle — 15 years of smoking one-half a pack of cigarettes per day

As noted by the Board, all of the physicians agree, and Claimant testified, that he smoked only one-half a pack of cigarettes per day. The reported years of smoking vary from 10 to 20. This would equate to a 5 to 10 pack year smoking history. Based on Claimant's credible testimony at the

hearing, the undersigned finds that he smoked for a minimum of 8 pack years and no more than 10 pack years.

All of the physicians in this case conclude that the miner suffers from a totally disabling respiratory impairment. Moreover, all of the physicians, except for Dr. Branscomb, conclude that the miner suffers from coal workers' pneumoconiosis. Dr. Branscomb states that the Category 2 opacities, which he found on the miner's February 2000 study, were due to obesity, not coal dust exposure. Dr. Branscomb further maintains that the miner suffers from chronic obstructive pulmonary disease arising solely from his smoking history. Little weight is accorded Dr. Branscomb's opinion for two reasons. First, at the time Dr. Branscomb interpreted the February 2000 chest x-ray, he was neither a board-certified radiologist nor a B-reader. His lack of radiological qualifications, as compared to the other physicians of record who are B-readers or dually-qualified physicians, renders his interpretation of the study less reliable. Second, Dr. Branscomb offers no persuasive explanation regarding why the miner's chronic obstructive pulmonary disease is caused only by his smoking history. Dr. Branscomb states that smoking is the most common cause of chronic obstructive pulmonary disease. A statement of this generality, rather than focusing on the miner's specific condition, is not persuasive. *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985). As the miner spent 23 years in the coal mines, where he quit in 1996, and he smoked one-half a pack of cigarettes per day for 15 or 20 years, quitting in 1988, it was incumbent on Dr. Branscomb to explain how he could determine that the miner's obstructive impairment was due solely to his smoking history. Although Dr. Branscomb makes passing reference to ventilatory and blood gas testing in support of his opinion, he does not explain any correlation between the results of such testing and his diagnoses. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984) (an unsupported medical conclusion is not a reasoned diagnosis).

The remaining physicians of record conclude that the miner suffers from coal workers' pneumoconiosis. Drs. Castle and Fino based their clinical findings of coal workers' pneumoconiosis on chest x-ray interpretations, which remain uncontradicted on this record. Drs. Rasmussen and Forehand found the presence of both clinical and legal pneumoconiosis. The opinions of Drs. Fino, Castle, Rasmussen, and Forehand, with respect to this issue, are entitled to greater weight because they are better supported by the preponderance of the objective medical data of record, *i.e.* recent positive x-ray study and qualifying blood gas testing. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000) (chest x-ray and medical opinion evidence must be weighed together); *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986) (an opinion may be accorded greater weight because it is better supported by the objective medical data of record); *Morgan v. Bethlehem Steel Corp.*, 7 B.L.R. 1-226 (1984) (blood gas study results "may bear upon the existence of pneumoconiosis" where qualifying test results may indicate the presence of a disease process arising out of coal mine employment).

As a result, based on the evidence as a whole, it is determined that the miner has established that he suffers from coal workers' pneumoconiosis under 20 C.F.R. § 718.202 by a preponderance of the evidence.

II
Etiology of total disability

In its *Decision*, the Board concluded that the undersigned properly applied the amended regulatory provisions setting forth the standard for demonstrating the cause of the miner's total disability. The amended provisions at 20 C.F.R. § 718.204(c)(1) require that pneumoconiosis be a "substantially contributing cause" to his total disability. The phrase "substantially contributing cause" is demonstrated where the evidence establishes that pneumoconiosis:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1) (2000).

As previously noted, all of the physicians in this case conclude that Claimant suffers from a totally disabling respiratory impairment. Drs. Rasmussen and Forehand conclude that the impairment is caused by the miner's 23 years of coal dust exposure as well as his smoking history. Drs. Fino, Castle, and Branscomb, on the other hand, state that the miner's impairment is due solely to his eight to ten pack year history of smoking cigarettes.

Initially, it is noted that Dr. Branscomb's opinion is entitled to little weight because, while he stated that he "embrace[d]" the concepts of legal and clinical coal workers' pneumoconiosis, he found that Claimant suffered from neither form of the condition. *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995) (where the administrative law judge finds the presence of pneumoconiosis, then a medical opinion stating that the miner does not suffer from the disease "can carry little weight" in assessing the etiology of a miner's total disability). Dr. Branscomb does state at the very end of his opinion that, assuming the miner suffered from simple coal workers' pneumoconiosis, he still would not be totally disabled by the disease. Again, Dr. Branscomb states a medical conclusion with no supporting rationale. His opinion is, therefore, entitled to little weight on this issue. *See Fuller, supra*.

Dr. Fino's opinion is also not persuasive. In his report, Dr. Fino conducts a review of certain medical literature and concludes that, although they "do show that there can be statistically significant obstruction in some miners . . . the studies do not show that the obstruction is clinically significant." Dr. Fino testified that pneumoconiosis can cause minor obstructions which, in turn, do not cause an impairment. However, he finds that "[t]he impairing or disabling type of obstructive abnormality is associated with restriction due to significant scarring and fibrosis from pneumoconiosis that would be seen in very high categories of pneumoconiosis, such as a three slash two or greater." He further states that the medical literature and studies are flawed and were tainted by selection bias. In *Freeman United Mining Co. v. Summers*, 272 F.3d 473 (7th Cir. 2001) the Seventh Circuit was

confronted with similar statements by Dr. Fino and concluded the following:

> Dr. Fino stated in his written report of August 30, 1998 that 'there is no good clinical evidence in the medical literature that coal dust inhalation in and of itself causes significant obstructive lung disease.' (citation omitted). During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino and concluded that his opinions 'are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature.'

As a result, the court concluded that the ALJ properly gave less weight to Dr. Fino's opinion because it was "not supported by adequate data or sound analysis." Similarly, in this case, in the "Discussion" section of his report, Dr. Fino addresses the "flaws" which he found in numerous studies. He never specifically discusses and explains his conclusion that the miner's disabling respiratory impairment is solely due to his history of smoking, in light of his observations of the miner's condition during the examination or the results of the miner's objective testing. Dr. Fino's written report is unreasoned.

Moreover, Dr. Fino's deposition testimony lends little rationale for his conclusions. He merely states that the Category 1 pneumoconiosis seen on Claimant's x-ray study was such a "low profusion" that it "would not cause an impairment." He stated that simple coal workers' pneumoconiosis can be totally disabling only if there is a significant drop in the miner's PO2 values. In this case, the miner's PO2 values were consistently well below that required to establish total disability under the regulations. When asked whether the miner's qualifying blood gas study results demonstrated that he was totally disabled, Dr. Fino stated that he did not "go by those regulations" and he does not "determine whether someone is disabled just because they meet the regulatory standards." Dr. Fino's report and testimony regarding the cause of Claimant's total disability are not well-reasoned or well-documented and, therefore, they are accorded little weight.

Dr. Castle also attributes the miner's totally disabling respiratory impairment to his history of smoking. Dr. Castle stated that his conclusion was supported by the fact that the miner's ventilatory testing revealed a pure obstruction without restriction, gas trapping, and a minimum reduction in diffusing capacity after correction for alveolar volume. Dr. Castle opined that coal workers' pneumoconiosis would cause a mixed, irreversible impairment of obstruction and restriction. Moreover, he found that the miner's resting and exercise blood gas testing was qualifying, but there was some improvement in the oxygen values after exercise. If the miner's impairment was due to coal dust exposure, Dr. Castle reasoned that there would have been no improvement in his oxygen values with exercise.

Dr. Castle's opinion carries little probative value because there is empirical support that coal workers' pneumoconiosis may cause a purely obstructive defect. Moreover, although the blood gas study values improved slightly with exercise, they still yielded values well below that required to be qualifying and were, to a large extent, irreversible. In addition, Dr. Castle failed to explain the irreversible ventilatory study results and why these results are not supportive of a finding of coal

workers' pneumoconiosis. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986) (a report may be given little weight where it is inadequately reasoned).

On the other hand, Dr. Rasmussen concludes that the miner's totally disabling respiratory impairment is due to his histories of smoking and coal dust exposure. Moreover, Dr. Rasmussen's opinion is supported by the objective testing of record and by the opinion of Dr. Forehand, who also examined and tested the miner. Dr. Rasmussen noted that ventilatory testing revealed an irreversible, moderate obstructive impairment. This is consistent with the presence of coal workers' pneumoconiosis, which is irreversible and progressive. *Lave v. Hollow Coal Co. v. Lockhart*, 137 F.3d 799, 803 (4th Cir. 1992); *Barnes v. Mathews*, 562 F.2d 278, 279 (4th Cir. 1977) ("pneumoconiosis is a slow, progressive disease often difficult to diagnose at early stages"). The miner's diffusing capacity and maximum breathing capacity were also reduced, and his blood gas study results consistently yielded qualifying results which further support Dr. Rasmussen's conclusions. *See Morgan, supra*. The undersigned also reiterates that Dr. Rasmussen's credentials are the "most impressive" in this claim and further entitle his opinion to greater weight. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). By *Decision* dated September 2001, the undersigned stated the following, which was affirmed by the Board:

> Although Dr. Castle and Dr. Fino are Board-Certified in pulmonary diseases, I find the credentials of Dr. Rasmussen to be the most impressive based on his expertise in the specific area of black lung disease. He participated on several coal mine health and research advisory committees, including one which developed disability standards for the Federal Black Lung program. He also authored many articles relevant to the area of black lung disease and several which are specifically related to the effects of smoking and occupational exposure.

(*Decision* at p. 13). Therefore, based on Dr. Rasmussen's well-reasoned and well-documented report as well as his superior credentials, the undersigned finds that Claimant has established that coal workers' pneumoconiosis had a "material adverse effect" on his respiratory condition pursuant to 20 C.F.R.
§ 718.204(c)(1) (2001).

III
Onset of benefits

Claimant is entitled to benefits commencing on the date the medical evidence first establishes that he became totally disabled due to pneumoconiosis or, if such a date cannot be determined from the record, the month in which the miner filed his claim which, in this case, is January 2000. 20 C.F.R. § 725.503; *Carney v. Director, OWCP*, 11 B.L.R. 1-32 (1987); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1-47 (1990). Moreover, it is noteworthy that the date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1306, 1-1310

(1984).

By report issued in February 2000, Dr. Forehand concluded that Claimant was totally disabled due to pneumoconiosis. Dr. Rasmussen's subsequent findings support this determination. Pursuant to the Board's holdings in *Tobrey* and *Hall*, Claimant became totally disabled at some prior point in time. It cannot be determined from the medical evidence in this record the precise point at which Claimant became totally disabled due to the disease. Therefore, it is determined that benefits are payable from January 1, 2000, the month in which the miner's claim was filed. Accordingly,

ORDER

IT IS ORDERED that the claim for benefits filed by Marvin Proffitt is granted and the payment of benefits shall commence as of January 1, 2000.

IT IS FURTHER ORDERED that within thirty days of receipt of this *Decision and Order,* Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366. Counsel for the Director and for Employer shall have fifteen days from receipt of the petition to file any objections thereto with this Office and with Claimant's counsel. It is requested that the petition for services and costs clearly state (1) counsel's hourly rate and supporting argument or documentation therefor, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

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Thomas M. Burke
Associate Chief Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.